MANDATORY HIPAA FORM FOR ATHLETES!!

All student athletes are required to complete and return the following RELEASE form. This form will be required to ensure that we are in compliance with the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA law was put in place to ensure confidentiality of individuals requiring medical care. Every athlete has their individual rights protected for medical records. Even though our Certified Athletic Trainers have "shared" medical information on the athletes for years between Physicians and coaches, we must now by federal law have a signed authorization form permitting Geisinger to disclose protected health information about the student/athlete to the coaching staff. This would include the injury specifics, severity of the injury, and the status to return to play. In order for your son/daughter to be able to participate in athletics, a copy of this form will need to be on file at the school. This form will only need to be completed one time per year prior to the start of the sport season. These forms will be available in the main office at your school. We appreciate your help in ensuring that this form is completed and turned in prior to your son/daughters sports season.

Sincerely,

Mike Elder, MS, ATC, CSCS
Program Manager of Sports Medicine
Central / West Regions
Musculoskeletal Institute
Geisinger Sports Medicine
16 Woodbine Lane
Danville, PA 17822-5212
Office 570-271-6700 option 3
mdelder@geisigner.edu

AUTHORIZATION TO RELEASE ATHLETIC MEDICAL INFORMATION

Patient Name: _____
Address: _____
Address: _____
Birthdate: _____
Medical Record No.: _____

• GEISINGER EMPLOYEE USE ONLY •

[X] Geisinger Medical Center
100 N. Academy Avenue
Danville, PA 17822

[X] Geisinger Wyoming Valley Medical Center
1000 E. Mountain Boulevard
Wilkes-Barre, PA 18711

[X] Geisinger Clinic (GMG)
_____
_____
(Specify site and address)

(AS APPLICABLE)

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to: Officials of the school that I (Student Athlete) attend. This would include, the coaching staff, athletic directors, insurance carriers and health-care professionals who are involved with my participation in **interscholastic athletics.**

_____
(Address and Phone number of receiving party)

for the purpose of: X continuation of medical treatment X payment of bill X Worker's Compensation X education X legal purposes X insurance purposes X at the request of the patient or the patient's legal representative for personal access or other (specify): _____

The information to be released will cover the time period from 6/1/2024 to 6/1/2025

SPECIFIC INFORMATION TO RELEASE:

-All information concerning my health that impacts my ability to participate in interscholastic athletics. This may include information about injuries (such as sprains), surgeries, or medical conditions (such as concussions, asthma etc.). This is to inform the above referenced people of my health –related limitations and abilities to continue to participate in **interscholastic athletics.**

–To provide the above referenced people with information on how to help me safely participate in interscholastic athletics

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.

_____ Parent/guardian _____ Patient/athlete — My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence maybe released to the recipient noted above.

_____ Parent/guardian _____ Patient/athlete — My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information may be released to the recipient noted above.

_____ Parent/guardian _____ Patient/athlete — My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted above.

AUTHORIZATION SIGNATURES

Date: _____ **Patient/Athlete Signature:** _____

Date: _____ **Witness Signature:** _____

Date: _____ **Parent/Guardian Signature:** _____

Date: _____ **Witness Signature:** _____

********COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT********

Copy: Medical Record Copy: Patient

Geisinger
Orthopaedics
and Sports Medicine

Geisinger Sports Medicine Athletic Training Room Medical Information Sheet

Name: _____ Date of Birth: _____ Sex: M / F

School Sport(s): Fall: _____ Current Grade: 6 7 8 9 10 11 12
Winter: _____
Spring: _____

Name of Parent/Guardian: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact in case parent/guardian cannot be reached:

Name & Relationship: _____ Phone: _____

Primary Physician: _____ Insurance Company: _____

PERMISSION FOR TREATMENT:

The certified athletic training staff will be available to provide preventive care, evaluation, emergency care, Impact/concussion testing, treatment and rehabilitation to all student-athletes. I give my permission for my son/daughter to be treated by the Athletic training staff, the physician in attendance and in the event of an emergency, at the local hospital or dispensary if necessary.

Signature of Parent or Guardian: _____ **Date:** _____

PERMISSION FOR MEDICATION:

I, _____, hereby give the athletic trainer permission to provide the following Medications to my son/daughter, _____, on an as needed basis.

_____ Acetaminophen (Tylenol)

_____ Ibuprofen (Advil, Motrin)

_____ Naproxen Sodium (Aleve)

_____ Antihistamines (Seasonal - Claritin, Zyrtec)

_____ Benadryl

_____ Antacid (Tums)

Signature of Parent or Guardian: _____ **Date:** _____

ACKNOWLEDGEMENT OF CARE

Should your child be seen by a physician regarding any injury or life threatening illness, a physician's progress note must be presented to the school's athletic trainer from the treating physician. Return to play decision resides with the school's athletic trainer and ultimately with the school's team physician.

State mandate (Sports Safety Act) requires guidelines or protocols be established for returning an athlete to play post-concussion. Geisinger's protocol requires all concussions to go through a series of progressive steps before returning to any practice or game. Geisinger's return to play protocol is available upon request from your athletic trainer.

Signature of Parent or Guardian: _____ **Date:** _____

Geisinger
Orthopaedics
and Sports Medicine

Preseason Sports Injury Health History Form

Name: _____ Sport: _____

GENERAL MEDICAL CONDITIONS, please "X" all that apply:

_____ Asthma _____ Diabetes _____ High Blood Pressure _____ Sickle Cell
_____ Bee Sting Allergy _____ Heart Murmur _____ Marfan's Syndrome
_____ Seizure Disorder _____ Migraine Headaches _____ Other: _____

ASTHMA

How often does the athlete need to use a rescue inhaler? Monthly Weekly Daily Other_____
What is the name of the inhaler? _____
IS THIS INHALER REQUIRED AT PRACTICES/GAMES? Yes / No
Triggers: _____ (Exercise, Allergies, Temperature, Sickness)

DIABETES

How is it being managed? Insulin pump Insulin injections OTHER _____
*What works the best when your child's blood sugar is low? (ex: glucose tabs, peanut butter, juice, etc)*_____

ALLERGIES (OTHER THAN SEASONAL) _____
Does this allergy require the use of an Epi-Pen? Yes / No
Does the Epi-Pen need to be with your child at all times? Yes / No

Are you currently taking any medications? _____ Yes _____ No
If so, please list: _____

Are you currently under a physician's care? _____ Yes _____ No
If so, please explain: _____

ORTHOPAEDIC INJURIES

Has your child ever had, or now have, any injury to any of the following:

	Yes	Left/Right	Explain
Shoulder/Elbow	____	____	_____
Wrist/Hand	____	____	_____
Back/Ribs/Spine	____	____	_____
Hip/Groin/Thigh	____	____	_____
Knee/Shin/Calf	____	____	_____
Ankle/Foot	____	____	_____
Neck/Head	____	____	_____

CONCUSSIONS

Has your child ever been diagnosed with a concussion? ____Yes ____No
How many? _____ List the dates of the concussions (if known) _____

Does your child have any other medical condition of which the athletic trainer should be aware?
_____
_____
_____

Signature of Parent or Guardian: _____ **Date:** _____

Copy: Patient